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GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2023 OneCare Revised Budget and Certification

Preliminary Staff Review

May 3, 2023

Agenda

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- Background/Process
- Certification
- Revised Budget Overview
- FY23 Budget Order status
- Board Questions and Discussion

FY23 ACO Revised Budget: Key Areas of Review

- Benchmarking
- Financials
- Attribution
- Payer Programs and Risk Model
- Population Health Program

Timeline

- **5/5** – OneCare Hearing on FY23 Revised Budget
- **5/17** - GMCB Staff Presentation – OneCare FY23 Revised Budget Recommendations
- **5/24 or 5/31** – Potential Vote on OneCare FY23 Revised Budget

ACO Oversight Statute/Rule

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- Oversight of Accountable Care Organizations (18 V.S.A. § 9382 and Rule 5.000)
  - **Certification**: Occurs one-time following application for certification; eligibility verifications performed annually.
  - **Budget**: Review of ACO budget occurs annually, usually in the fall prior to start of budget/program year; payer contracts/attribution are finalized by spring of the budget year and the ACO submits a revised budget.

OneCare Vermont ACO Revised FY23 Budget

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- Budget guidance and budget order require a revised ACO budget to be presented in the spring of the budget year
  - Revised budget to include elements described in the FY23 Budget Order
- Budget adjustment process established in Rule 5.000, §5.407:
  - Staff will review and come back to the Board with any performance that has “varied substantially from its budget”
  - If performance has “varied substantially” from ACO’s budget, then, upon application of ACO, Board may adjust ACO’s budget
  - OneCare has not submitted a budget amendment request; Potential vote noticed for May 24th or May 31st

§5.407 Budget – Performance Review and Adjustment

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a) The Board may conduct an independent review of an ACO's performance under an established budget at any time. Such a review need not be limited to financial performance and may cover any matter approved by the Board as part of the ACO's budget. The Board may request, and an ACO must provide, information determined by the Board to be necessary to conduct the review. If, after conducting a review, the Board determines that an ACO's performance has varied substantially from its budget, the Board shall provide written notice to the ACO. The notice shall set forth the results of the Board's review, as well as a description of the facts the Board considered.

b) After determining that an ACO's performance has varied substantially from its budget, and upon application of the ACO, the Board may adjust the ACO's budget. In considering an adjustment of an ACO's budget, the Board will consider the financial condition of the ACO and any other factors it deems appropriate.

c) An ACO must request and receive an adjustment to its budget under subsection (b) of this section prior to executing a Risk Contract that would cause the ACO to exceed a Risk Cap established by the Board as part of the ACO's budget.

d) The Board may take any and all actions within its power to compel compliance with an established budget.

OneCare Vermont ACO FY23 Budget – Revised Budget, Condition 12

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At its presentation of the revised budget OneCare must present to the GMCB on the following topics:

a. Final FY2023 attribution and finalized payer contracts;
b. Revised budget, based on final attribution;
c. Final description of population health initiatives;
d. Expected hospital dues for 2023 by hospital;
e. Expected risk for 2023 by OneCare held risk, risk bearing entity and by payer;
f. Any changes to the overall risk model for 2023;
g. Source(s) of funds for OneCare's 2023 population health management programs;
h. Status of the Medicare ACO Performance benchmarking system;
i. Update on the results of evaluations as described in the FY23 budget submission;
j. Update on the partnership between OneCare and the University of Vermont to explore additional partnerships around evaluation;
k. OneCare's progress relative to targets for commercial payer FPP levels; and
l. Any other information the GMCB deems relevant to ensuring compliance with this order.

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STAFF ANALYSIS
FY23 CERTIFICATION REVIEW

FY 2023 Certification Eligibility Verification

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Once certified, an ACO must annually submit a form to the GMCB (1) verifying that the ACO continues to meet the requirements of 18 V.S.A. § 9382 and Rule 5.000; and (2) describing in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in the certification sections of Rule 5.000.

- **5.201** - Legal Entity
- **5.202** - Governing Body
- **5.203** - Leadership and Management
- **5.204** - Solvency and Financial Stability
- **5.205** - Provider Network
- **5.206** - Population Health Management and Care Coordination
- **5.207** - Performance Evaluation and Improvement
- **5.208** - Patient Protections and Support
- **5.209** - Provider Payment
- **5.210** - Health Information Technology

Certification
Executive Compensation

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- Board issued guidance regarding Rule 5.000, § 5.203(a) on May 12, 2021.

"To comply with § 5.203(a) of the Rule an ACO must structure its executive compensation to achieve specific and measurable goals that support the ACO's efforts to reduce cost growth or improve the quality and overall care of Enrollees, or both."

- Additional materials requested:
  - Final FY23 corporate goals upon which executive variable pay is based
  - All metrics associated with these goals
  - A description of any numerical scoring used to determine how the achievement or partial achievement of goals are scored to correlate with the amount of variable pay awarded
  - Variable pay ranges for eligible executive positions for FY23
  - All UVM Health Network policies related to executive compensation and variable compensation

Certification
Executive Compensation

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FY 2023 corporate goals upon which executive variable pay is based:

- Develop a plan for future (2024+) value-based care contracts, to include:
  - Payer contracts
  - CPR program
  - PHM Accountability advancements
- Integrate health disparities findings into PHM model for 2024 to align incentive structure to minimize health disparities
- Successfully transition to a new data platform
- Develop comprehensive OneCare evaluation strategy and action plan for CPR and PHM programs

Executive Compensation
Variable Pay Ranges

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- Variable pay ranges, as a percentage of base pay
  - 0-10% Directors
  - 0-20% VPs
  - 0-25% CEO
- Determination of the attainment of these goals is made by the next level of leadership. In the case of the CEO, the Executive Committee of the OneCare Board of Managers (BOM) reviews and makes recommendations to the OneCare BOM and the full OneCare BOM must approve the attainment of these goals.

Executive Compensation

FY 2023 Corporate Goals and Metrics

Payment Reform Priority: Evolve and enhance payment reform program
Network Performance Management Priority: Ensure a high quality, equitable system that continuously strives to improve health care delivery and outcomes
Data & Analytics Priority: Deliver actionable insights to network in support of better outcomes

Domain(s)	Goal	Weight	Metrics/Measurement*	
			Threshold**	Target***
All	Financial Management	Gate	Manage within the FY23 administrative budget and meet quality reporting requirements	N/A
Payment Reform; Network Performance Management	Develop a plan for future (2024+) value based care contracts, to include: • Payer contracts • CPR program • PHM Accountability advancements	40%	Engage network and key stakeholders to inform strategic planning process. Research and present draft findings of public and private value based future program options to the Board	Complete strategic planning with 75% or more of identified stakeholders completing structured interview and survey. Board approved 3-5 year strategic plan to begin 2024. Plan will include viable value based programs for execution and business structures needed to execute on any new or enhanced value based care program offerings
Network Performance Management	Integrate health disparities findings into PHM model for 2024 to align incentive structure to minimize health disparities	10%	A report to the Board on how OneCare has incorporated disparities scorecards findings into HSA Consultations	All HSAs select and incorporate selected areas of focus in QI efforts. OneCare reports to the Board on HSA engagement in focused QI efforts.
Data & Analytics	Successfully transition to a new data platform	30%	New baseline population health data reports are created and socialized with participants	By Q3, foundational population health reports are generated in the new analytics platform and pushed to the network electronically
Data & Analytics	Develop comprehensive OneCare evaluation strategy and action plan for CPR and PHM programs	20%	Evaluation Plan approved by governance committees	Evaluation findings incorporated into program planning and budget for 2024. Key findings made available publically.

* Metric completion is determined by validating completion of each component of measurement in each category (i.e. Threshold completion = 50% x Weight). The Board has latitude to adjust goals and weights if circumstances or priorities change during the year.

**Meeting Threshold indicates modest reward for good, "satisfactory performance" marked by substantial progress or improvement and noteworthy achievements. P50 represents median salary within pay band.

*** Meeting Target indicates reward for "strong performance" marked by achieving the target goal; multiple goals within each performance category may be weighted. P65 represents competitive salary (e.g. 65th %ile) within pay band.

Executive Compensation
FY 2023 Corporate Goals Q1 Update

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- Throughout the year, the status of each metric is assessed and updated quarterly.
  - FY 2023 Quarter 1 Update as presented in OneCare's April Board of Managers Meeting packet (on the following slide)

Domain(s)	Goal	Weight	Metrics/Measurement*		Q1, 2023 Update		
			Threshold**	Target***	Status	% Complete/Measure	Briefly describe current state, risks, mitigations and next steps
All	Financial Management	Gate	Manage within the FY23 administrative budget and meet quality reporting requirements	N/A	In Progress	25%	Board approved 2023 revised budget. Annual quality abstration delayed by payer, new deadline May 2023. Monitoring PHM performance against targets to assess budgetary risk.
Payment Reform; Network Performance Management	Develop a plan for future (2024+) value based care contracts, to include: . Payer contracts . CPR program . PHM Accountability advancements	40%	Engage network and key stakeholders to inform strategic planning process. Research and present draft findings of public and private value based future program options to the Board	Complete strategic planning with 75% or more of identified stakeholders completing structured interview and survey. Board approved 3-5 year strategic plan to begin 2024. Plan will include viable value based programs for execution and business structures needed to execute on any new or enhanced value based care program offerings	In Progress	25%	Strategic planning engagement completed by stakeholders: Network (100%), key stakeholders (100%), and staff (85.1%). Initial themes presented to Board of Managers on 3/21/22. Work proceeding to develop resulting strategic plan.
Network Performance Management	Integrate health disparities findings into PHM model for 2024 to align incentive structure to minimize health disparities	10%	A report to the Board on how OneCare has incorporated disparities scorecards findings into HSA Consultations	All HSAs select and incorporate selected areas of focus in QI efforts. OneCare reports to the Board on HSA engagement in focused QI efforts.	In Progress	25%	HSA consultations in process for March and April to include HSA-level disparity insights. This report is expected to be presented to the Board of Managers in May.
Data & Analytics	Successfully transition to a new data platform	30%	New baseline population health data reports are created and socialized with participants	By Q3, foundational population health reports are generated in the new analytics platform and pushed to the network electronically	In Progress	25%	Arcadia go-live date revised to October 2023 due to extenuating circumstances. Recommend Board consider adjusting target timeline to end of Q4. Management is working to mitigate delays through close management of the rollout plan.
Data & Analytics	Develop comprehensive OneCare evaluation strategy and action plan for CPR and PHM programs	20%	Evaluation Plan approved by governance committees	Evaluation findings incorporated into program planning and budget for 2024. Key findings made available publically.	In Progress	25%	The Board approved plan to hire external national evaluation contractor. Vendor selection hampered by complexity (limits the pool) and existing potential and/or perceived conflicts of interest. Final vendor selected late March and contract negotiations underway.

Certification
Next Steps

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- OneCare revised FY 2023 budget presentation on May 5, 2023
  - OneCare may present additional information related to executive compensation.
- Following OneCare's presentation GMCB staff will send a memo to the Board outlining a full review of certification eligibility verification for FY 2023.
- The GMCB does not need to vote in order to continue OneCare's certification.
- Action would be needed if the GMCB concludes that OneCare no longer meets the requirements to be eligible for certification. In that case, the Board would provide notice to the ACO and an opportunity to respond before requiring corrective action.

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STAFF ANALYSIS
FY23 REVISED BUDGET

Condition 1
ACO Benchmarking

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OneCare must continue to support an ACO performance benchmarking tool that compares key quality, cost, and utilization metrics to national ACO metrics in accordance with its FY22 Budget Order and further defined by this Order.

The ACO performance benchmarking tool must:

(see subsequent slides)

Condition 1
ACO Benchmarking

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Requirement:

a. Allow the ACO and GMCB to assess OneCare's performance against peer ACO's or integrated health systems by comparing OneCare ACO-level performance metrics to a broad national cohort of ACOs in five key areas, as available and appropriate:
   i. Utilization
   ii. Cost per capita
   iii. Patient satisfaction/engagement
   iv. Quality
   v. Evidence-based clinical appropriateness

Submission:

- Report submitted 3/31/23
- Report includes benchmark analyses for two national cohorts ("Peer ACO Cohort" and "All ACO Cohort")
- Metrics selected by OCVT based on broad list provided by GMCB

Condition 1
ACO Benchmarking

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Requirement:

b. Compare ACO performance metrics to at least the 50th and 90th percentiles, though comparison by quartile or decile is preferred, by each metric to allow for identification of top performers by measure in each key area.

Submission:

- 10th, 50th and 90th percentile comparisons are provided for the "All ACO Cohort"; for the "Peer ACO Cohort" just the average is provided
- Report: "Note that the 10th, 50th and 90th percentile cohorts are calculated based on the 10th/50th/90th percentile of each risk-adjusted metric calculated in isolation (e.g., the 10th/50th/90th percentile best performing ACO w/ respect to IP admission counts may be different from the 10th/50th/90th percentile best performing ACO w/ respect to SNF admissions)."

Condition 1
ACO Benchmarking

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- "Peer ACO Cohort" (20 ACOs)
  - Report indicates where OCVT is "better" or "worse" than the average.
  - Note there are inverse metrics where higher is better and the color-coding is not adjusted.
  - Does not indicate "top performing" ACOs by metric or overall.
- "All ACO Cohort" (513 ACOs)
  - Report indicates where OCVT performance is "better" or "worse" than the ACO at the 10th, 50th, and 90th %tiles.
  - Indicates "top performing" ACO by metric, and the "best" comparison ACO may be (is likely) different for each metric

Condition 1
ACO Benchmarking

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Requirement:

c. Enhance OneCare's ACO-level performance management strategy, including integration of best practices and priority opportunities identified through benchmarking and peer networking in the OneCare Quality Evaluation and Improvement Program.

Submission:

- OCVT states "it intends to use its report to identify areas of opportunity, and to work with its vendor to identify high performing organizations within its National ACO Peer Cohort that align with OneCare's priorities."
- This is the second iteration of this report (first was Oct. 2022). Confirm which report OCVT intends to maintain for performance management and improvement.
- GMCB and OCVT continue to discuss how the report will meet this requirement.

Condition 1
ACO Benchmarking

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Requirement:

d. Improve regulatory reporting and performance assessment by providing the benchmarking comparisons to targets at least semiannually to the GMCB.

i. FY23 Guidance laid out future expectations for setting targets for performance benchmarks at or above the 50th percentile and that any Performance Improvement Plans should include best practices identified through top performers (90th percentile).

Submission:

- GMCB will determine how to incorporate into FY24 budget guidance (spring 2023)

Condition 1
ACO Benchmarking

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Requirement:

e. An updated benchmarking report must be submitted to the Board by March 31, 2023.

f. Meet the standards and methods for the report as specified by this Order and the ACO Reporting Manual. The GMCB Board Chair is authorized to delegate authority to one or two GMCB Board Members and the GMCB Director of Health Systems Policy to review and approve proposed revisions to the report.

Submission:

- OCVT required to submit an updated report twice each year in October and March (budget and revised budget)
- GMCB still assessing the March 31 report

Condition 1
ACO Benchmarking – KEY QUESTIONS

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1. The development of this report has been an iterative process between GMCB, OCVT, and their vendor. Is the GMCB ready to accept this report for use as a consistent performance measurement tool? Does OCVT intend to use this report in creating their budget and in their Quality Evaluation and Improvement program?
2. The GMCB required establishing ACO performance benchmarks to help answer the following questions: “How well can an ACO perform in each metric? How does OCVT perform in each metric in comparison to an ACO that gets the best result in each metric?”

Condition 1

ACO Benchmarking – KEY QUESTIONS (cont.)

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3. Does the March 31 report allow GMCB to track OCV performance over time?
4. What are the strengths and weaknesses of this report to show us the relationship between OCVT efforts and performance improvement?
5. Does this report allow OCVT to calculate a return on investment (ROI) of population health investments, payment initiatives, and administrative expenses?

	2019		2020		2021	
	OCV	Top 10% All ACOs	OCV	Top 10% All ACOs	OCV	Top 10% All ACOs
Outpatient Care / 1000						
ED visits						
ED Cost of Care PBPM ($)						
PCP visits						
PCP Cost of Care PBPM ($)						
Inpatient Facility - Medical / 1000						
Admissions						
Hospital Days						
Total Cost of Inpatient Care PBPM ($)						
Ambulatory Care Sensitive Admissions / 1000						
Prevention Quality Overall Composite						
Prevention Quality Acute Composite						
Prevention Quality Chronic Composite						
Prevention Quality Diabetes Composite						
Congestive Heart Failure						
Community-Acquired Pneumonia						
Urinary Tract Infection						
Chronic Obstructive Pulmonary Disease						
Diabetes-Long Term Complications						
Hyptertension						
Lower Extremity Amputation due to Diabetes						
Diabetes Short Term Complications						
Uncontrolled Diabetes						
Asthma in Younger Adults						
Total Cost of Care PBPM ($)						

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Notes:

- Compare OCVT performance to top 10th% All ACOs, year over year
- Top 10th% is not a static group of ACOs, likely different for each measure
- Color code report to indicate over/under top 10th% and average
- Include selected key metrics

Condition 5

BCBSVT Withdrawal from OneCare

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5. The GMCB's approval of OneCare's FY23 budget is conditioned on OneCare participating in FY23 in the Vermont Medicare ACO Initiative and Medicaid Next Generation ACO Program. OneCare must submit an updated budget to the GMCB for review no later than January 30, 2023 reflecting the effects of BlueCross BlueShield of Vermont's decision not to participate with OneCare in FY23.

- BCBSVT announced on 12/20/22 that it did not plan to continue participation with OneCare in FY23
  - BCBSVT Press Release
- On 12/21, OneCare notified GMCB of this change; notification left an open door for negotiations to resume
- On 1/30/23, OneCare resubmitted their budget through the lens of the BCBSVT withdrawal

Discuss: GMCB's Preferred Approach

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AMOUNT: $1.8M in budgeted hospital participation fees; could include $98K in operational savings (does not include GMCB ordered 2% admin reduction)

POTENTIAL APPROACHES: Note that all funds must be "reasonably related to ACO Activities" to be compliant with federal law.

1. **Reduce fees based on the loss of attributed lives**
   - Accurately reflects loss of attributed lives but does not provide relief to impacted primary care practices
2. **Reinvest fees into existing OneCare primary care programs.** Some possible examples:
   - Raising Base PMPMs in other payer programs (provides timely relief for impacted primary care providers in 2023 but could lead to reduction in base PMPMs in 2024)
   - Raising Bonus payment amounts in other payer programs (provides relief for impacted primary care practices and avoids reduction to base PMPM in 2024; bonus payments are paid later after quality measures are final)
3. **Reinvest fees into other ACO programs** (e.g., other ACO PHM activity)
   - May not go to primary care providers; increases investment in population health; potential reduction in 2024

Condition 11
Revised Budget

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11. No later than March 31, 2023, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition [12]. Among the supporting documentation, OneCare must submit:

a. Final payer contracts;

b. Attribution by payer;

c. A revised budget, using a template provided by GMCB staff;

d. Final descriptions of OneCare's population health initiatives, including final care coordination payment model;

e. Hospital dues for 2023 by hospital;

f. Hospital risk for 2023 by hospital and payer;

g. Documentation of increasing the OneCare held risk in the amount ordered by the GMCB and any changes to the overall risk model for 2023;

h. Source of funds for its 2023 population health management programs;

i. Revised benchmarking report pursuant to Condition 1;

j. A report to the Board on OneCare's progress relative to its targets for commercial payer FPP levels; and

k. Any other information the GMCB deems relevant to ensuring compliance with this order.

Condition 11.a

Final Payer Contracts

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- Payer contracts for Medicare, Medicaid, and MVP were provided to the Board staff in February
- New UVMHN Self-Funded program contract has not yet been signed; OCV has confirmed they will provide this to staff within 10 business days of completion.

Condition 11.b

Starting Attribution by Payer

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Payer Program	# of Hospitals Participating	# and type of hospital			FY23 Starting Attribution (Initial Budget)	FY23 Starting Attribution (Revised Budget)
		CAH	Acute Care	AMC		
Medicare	9	3	5	1	67,558	68,605
Medicaid	14	7	5	2	Traditional: 95,175 Expanded: 30,563	Traditional: 105,101 Expanded: 37,308
BCBSVT	0	0	0	0	92,940	0
UVMHN Self-Funded	8	4	2	2	0	11,010
MVP	13	6	5	2	10,422	8,915
Any Payer Program	14	7	5	2	296,658	230,939

CAH – Critical Access Hospital
AMC – Academic Medical Center

Condition 11.b
Anticipated Impact of 2023 Medicaid Redeterminations

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FY22			FY23 – Initial Budget			FY23 – Revised Budget			FY23 Q1 Reporting
Starting Attribution*	Average Attribution**	% change	Starting Attribution**	Average Attribution**	% change	Starting Attribution*	Average Attribution**	% change	Starting Attribution *
126,288	113,974	-9.75%	125,738	109,155	-13.2%	142,409	126,354	-11.3%	130,882

* Actual
** Estimated

Condition 11.c
ACO Budget & Financials
Full Accountability Summary Income Statement

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OneCareVT (Full Accountability Income Statement)					
	FY2022A	FY2023B	FY2023R2	FY23B vs. FY23R2 ($)	FY23B vs. FY23R2 (%)
Program Target Revenue	808,944,098	974,663,796	526,004,685	(448,659,111)	-46%
Payer Program Support Revenue	455,037,220	448,739,073	451,133,516	2,394,443	1%
State Support	-	-	-	-	
Grant Revenue	-	-	-	-	
MSO Revenues	-	-	-	-	
Other Revenue	25,596,063	25,491,500	23,556,500	(1,935,000)	-8%
Total Revenue	1,289,577,381	1,448,894,369	1,000,694,701	(448,199,668)	-31%
Expenses	793,488,829	965,117,880	516,458,769	(448,659,111)	-46%
Operational Expenses	13,543,183	15,189,971	14,791,715	(398,256)	-3%
PHM/Payment Reform Programs	481,505,645	468,586,518	469,444,217	857,699	0%
Total Expenses	1,288,537,657	1,448,894,369	1,000,694,701	(448,199,668)	-31%

Staffing				
FTEs	63	-	47	
Salaries / Benefits	-	-	8,059,973	

ACO Budget & Financials

Budget Components: Full Accountability Revenue (2019-2023)

	FY2022A	FY2023B	FY2023R2	FY23B vs. FY23R2 ($)	FY23B vs. FY23R2 (%)
Program Target Revenue	**808,944,098**	**974,663,796**	**526,004,685**	**(448,659,111)**	**-46%**
Payer Program Support Revenue	**455,037,220**	**448,739,073**	**451,133,516**	**2,394,443**	**1%**
Other Revenue	**25,596,063**	**25,491,500**	**23,556,500**	**(1,935,000)**	**-8%**
Total Revenue	**1,289,577,381**	**1,448,894,369**	**1,000,694,701**	**(448,199,668)**	**-31%**

Expenses	**793,488,829**	**965,117,880**	**516,458,769**	**(448,659,111)**	**-46%**
Health Services Spending	814,765,963	-	-	-	
OneCare Hospital Payments	-	965,117,880	516,458,769	(448,659,111)	-46%
Expected Spending Under (Over) Claims Target	(23,277,134)	-	-	-	
Other Expenses	2,000,000	-	-	-	
Operational Expenses	**13,543,183**	**15,189,971**	**14,791,715**	**(398,256)**	**-3%**
Salaries & Benefits	8,153,830	8,704,465	8,059,973	(644,492)	-7%
Contracted Services	-	3,369,471	3,745,930	376,459	11%
Software	2,259,168	1,871,810	1,734,949	(136,861)	-7%
Insurance	-	261,000	261,000	-	0%
Supplies	-	35,099	31,300	(3,799)	-11%
Travel	-	25,975	25,800	(175)	-1%
Occupancy	-	71,455	50,775	(20,680)	-29%
Other Expenses	1,563,239	850,696	881,988	31,292	4%
Purchased Services	1,566,946	-	-	-	
FPP	**444,914,920**	**438,664,506**	**443,189,489**	**4,524,983**	**1%**
PHM/Payment Reform Programs	**36,590,725**	**29,922,012**	**26,254,728**	**(3,667,284)**	**-12%**
Total Expenses	**1,288,537,657**	**1,448,894,369**	**1,000,694,701**	**(448,199,668)**	**-31%**

ACO Budget & Financials

Budget Components: Full Accountability Expenses (2019-2023)

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	FY2022A	FY2023B	FY2023R2	FY23B vs. FY23R2 ($)	FY23B vs. FY23R2 (%)
Expenses	**793,488,829**	**965,117,880**	**516,458,769**	**(448,659,111)**	**-46%**
Operational Expenses	**13,543,183**	**15,189,971**	**14,791,715**	**(398,256)**	**-3%**
PHM/Payment Reform Programs	**481,505,645**	**468,586,518**	**469,444,217**	**857,699**	**0%**
FPP	**444,914,920**	**438,664,506**	**443,189,489**	**4,524,983**	**1%**
Population Health Mgmt Pymt	**9,469,594**	**-**	**-**	**-**	
Complex Care Coordination Program	**5,901,304**	**-**	**-**	**-**	
Value-Based Incentive Fund	**1,569,923**	**-**	**-**	**-**	
Comprehensive Payment Reform Program	**1,750,164**	**1,510,492**	**1,617,513**	**107,021**	**7%**
Program Match	**82,500**	**-**	**-**	**-**	
Amplify Grants	**34,521**	**-**	**-**	**-**	
DULCE	**204,485**	**145,366**	**145,366**	**-**	**0%**
Longitudinal Care	**365,120**	**399,000**	**399,000**	**-**	**0%**
Chronic Kidney Disease	**23,166**	**-**	**-**	**-**	
Mental Health Initiatives	**64,553**	**-**	**-**	**-**	
Innovation Fund	**54,236**	**69,667**	**69,667**	**-**	**0%**
Mental Health Screening Initiative	**-**	**-**	**1,638,140**	**1,638,140**	
PCMH Legacy Payments	**2,050,951**	**2,163,158**	**2,062,850**	**(100,308)**	**-5%**
CHT Funding Risk Communities	**2,739,498**	**2,874,062**	**2,974,370**	**100,308**	**3%**
SASH Funding Risk Communities	**4,285,796**	**4,508,696**	**4,508,696**	**-**	**0%**
PCP Engagement Medicaid Expanded	**(12,500)**	**-**	**-**	**-**	
PCP Engagement BCBSVT Primary	**-**	**-**	**-**	**-**	
VBIF Reinvestment Expense	**6,000**	**296,240**	**296,240**	**-**	**0%**
Settlement Expense	**7,999,389**	**-**	**-**	**-**	
PHM Base Payment	**-**	**15,274,117**	**11,425,898**	**(3,848,219)**	**-25%**
PHM Bonus Potential	**-**	**2,329,915**	**765,689**	**(1,564,226)**	**-67%**
Specialist Funding	**2,025**	**150,000**	**150,000**	**-**	**0%**
SNF Support	**-**	**201,299**	**201,299**	**-**	**0%**
Total Expenses	**1,288,537,657**	**1,448,894,369**	**1,000,694,701**	**(448,199,668)**	**-31%**

High-Level Overview
Administrative/Operational Costs

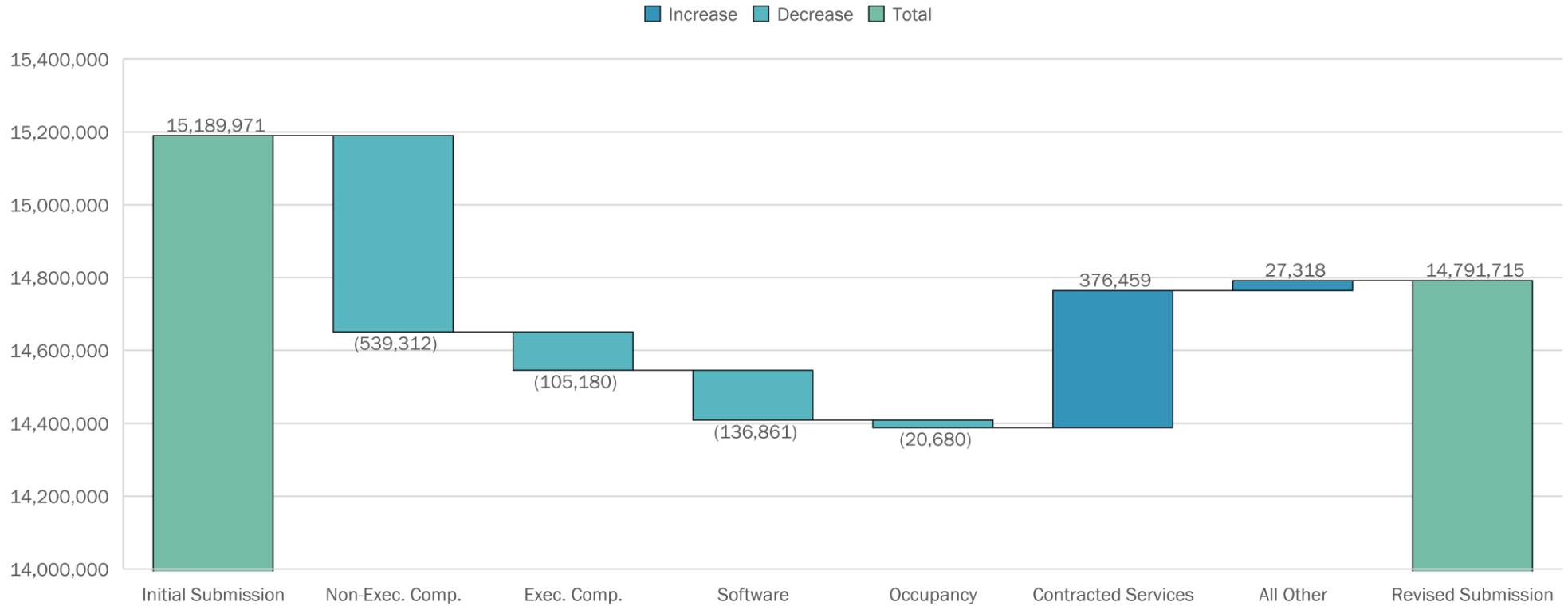
VERMONT
GREEN MOUNTAIN CARE BOARD

Initial Submission	15,189,971
Executive Compensation	(105,180)
Non-Exec. Compensation	(539,312)
Contracted Services	376,459
Software	(136,861)
Insurance	-
Supplies	(3,799)
Travel	(175)
Occupancy	(20,680)
Other Expenses	31,292
Revised Submission	14,791,715

ACO Budget & Financials

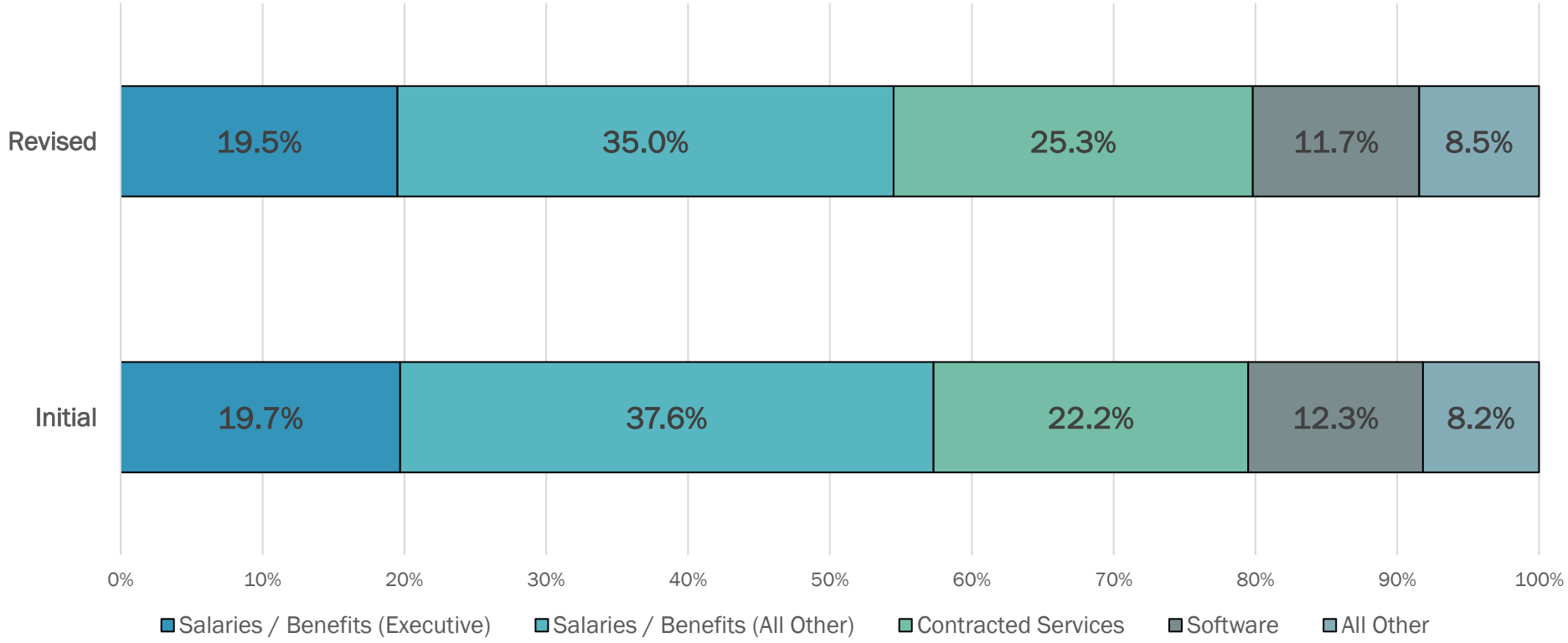
FY23 Initial to Revised Budget
Operating Expenses Reconciliation

VERMONT
GREEN MOUNTAIN CARE BOARD



ACO Budget & Financials

Operating Expense Concentrations: Initial vs. Revised Budget



ACO Budget & Financials

FTE Count

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GREEN MOUNTAIN CARE BOARD

	FY22	FY23 Revised	Delta
Operations	7.00	4.00	(3.00)
Finance	12.50	12.00	(0.50)
Public Affairs	5.50	5.75	0.25
Compliance	3.00	2.00	(1.00)
Central Admin	6.10	6.05	(0.05)
Contracting	4.00	4.00	-
Value-Based Care	24.80	12.90	(11.90)
Total	62.90	46.70	(16.20)

ACO Budget & Financials

PHM Expenditures: Initial vs. Revised Budget

VERMONT
GREEN MOUNTAIN CARE BOARD

PHM Programs (Less FPP)	Initial	Revised
Hospital/ Hospital PCP	$ 10,250,510	$ 8,667,414
Independent PCP	$ 5,618,833	$ 5,062,679
FQHC	$ 6,143,166	$ 5,198,308
Specialist	$ 185,549	$ 185,549
Designated Agency	$ 1,297,403	$ 722,947
Home Health	$ 1,423,634	$ 1,414,915
Area Agency on Aging	$ 211,774	$ 211,774
SASH	$ 4,508,696	$ 4,508,696
Other / TBD	$ 282,445	$ 282,445
Total	**29,922,010**	**26,254,726**

ACO Budget & Financials

Spending per Life

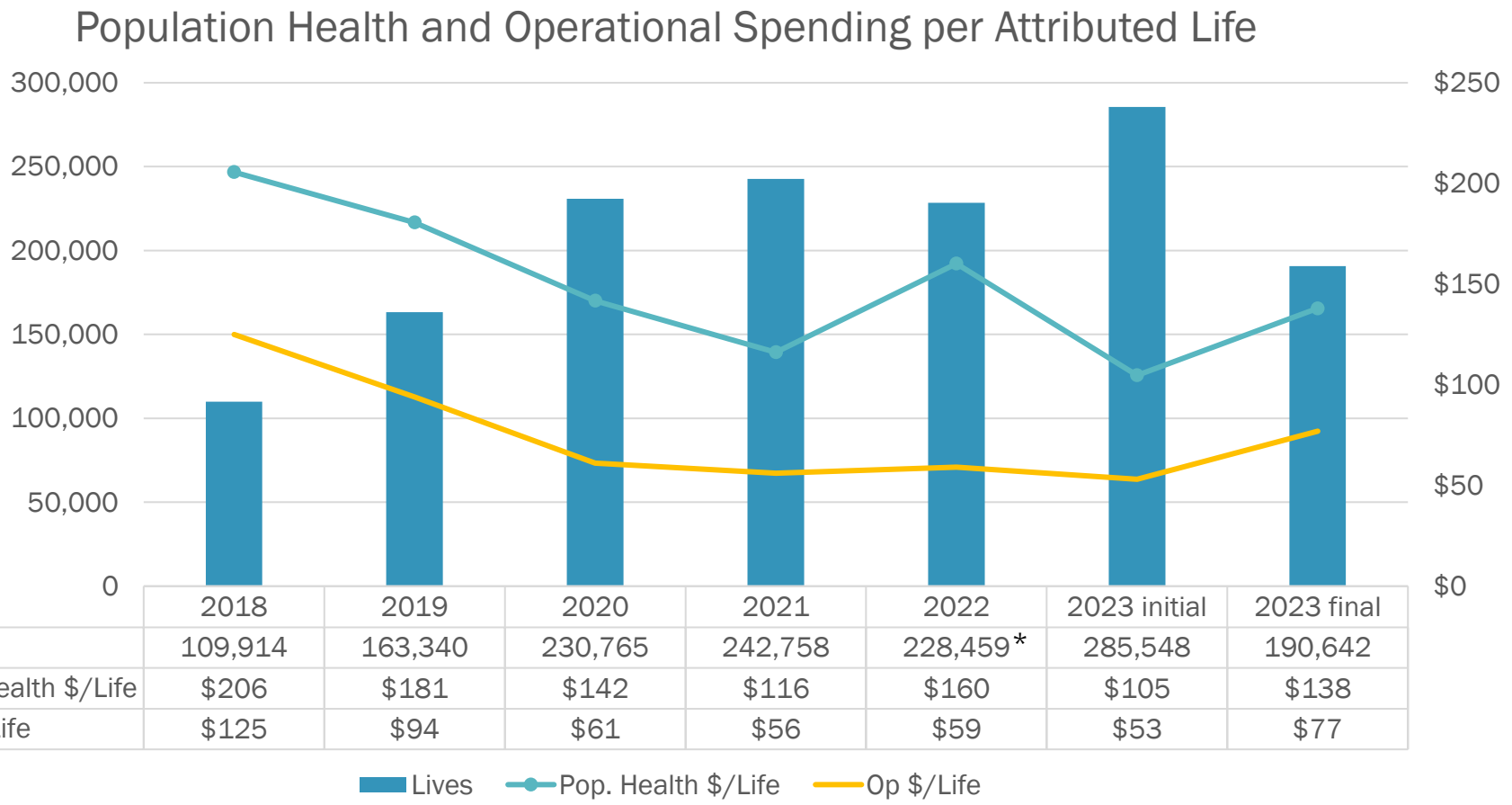
VERMONT
GREEN MOUNTAIN CARE BOARD

	2018	2019	2020	2021	2022	2023 Initial	2023 Final
Average Attributed Lives	109,914	163,340	230,765	242,758	228,459*	285,548	190,642
Pop Health Spending	$22.6M	$29.5M	$32.7M	$28.2M	$36.6M	$29.9M	$26.3M
Pop Health Exp per Attributed Life	$206	$181	$142	$116	$160	$105	$138
Operating Expenses	$13.7M	$15.3M	$14.0M	$13.6M	$13.5M	$15.2M	$14.8M
Operating per Attributed Life	$125	$94	$61	$56	$59	$53	$77

*estimated
Note: Rounding may cause slight variations in calculations above

ACO Budget & Financials

Spending per Life



	2018	2019	2020	2021	2022	2023 initial	2023 final
Lives	109,914	163,340	230,765	242,758	228,459*	285,548	190,642
Pop. Health $/Life	$206	$181	$142	$116	$160	$105	$138
Op $/Life	$125	$94	$61	$56	$59	$53	$77

*estimated
Note: Rounding may cause slight variations in calculations above

Condition 11.d

Population Health Updates

VERMONT
GREEN MOUNTAIN CARE BOARD

- New primary care initiative: Mental Health Screening and Follow-Up
- $1.6M to primary care - semi-annual payments - $9.72 per attributed life based on estimated mid-year assigned attributed lives
- Optional participation, offered for one year (2023)
- To qualify for the initial incentive payment of $9.72 per attributed life, primary care participants must *attest to perform* clinically appropriate annual mental health screening for patients twelve years of age or older, electronically record screening results, treatment, and follow-up.
- To qualify for the second incentive payment of $9.72 per attributed life, participants must have earned the first payment, and electronically report screening rates and follow-up/treatment rates to OneCare.

Condition 11.g

Changes to Risk Model

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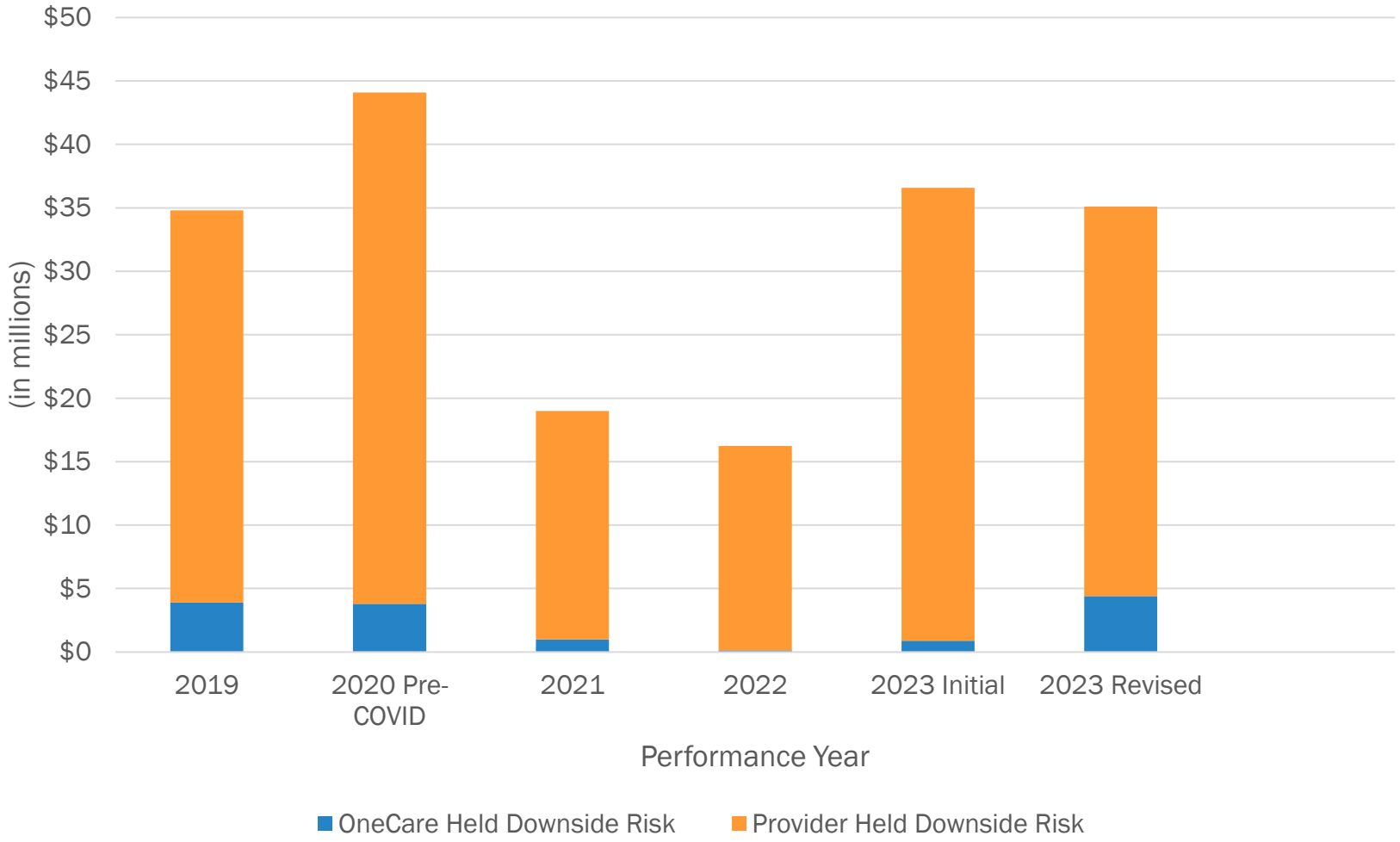
GREEN MOUNTAIN CARE BOARD

- Condition 16: "…**OneCare shall hold at least $3.9 million of the risk associated with Medicare Advanced Shared Savings Payments** and not pass that amount of the risk on to any OneCare network participant."
- OCV now holds $4.4M in downside risk at the entity-level ($3.9M of advanced shared savings and $444k for St. Johnsbury)
- OCV's entity-level potential upside potential gain is $861k
- Medicaid risk corridor increased from 2% up/down to 3% up/down
- MVP risk corridor also changed from initial budget
- The UVMHN self-funded plan was introduced since the initial budget submission

Condition 11.g
Total Risk and Reserves Over Time



Condition 11.g
Total Risk and Reserves Over Time

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GREEN MOUNTAIN CARE BOARD

	2019	2020	2021	2022	2023 initial	2023 revised
TCOC	$823.3M	$1,086.1M	$1,178.3M	$1,278.8M	$1,413.8M	$950.1M
Total Risk	**$34.8M**	**$44.1M**	**$19.0M**	**$16.2M**	**$36.5M**	**$26.7M up; $35.1M down**
Total Risk as % TCOC	4.2%	4.1%	1.6%	1.3%	2.6%	2.8% up; 3.7% down
Provider Held Risk	$30.9M	$40.3M	$18.0M	$16.1M	$35.7M	$25.8M up; $30.7M down
% of Total Risk	*89%*	*91%*	*95%*	*99%*	*98%*	*96.8% up; 87.4% down*
OneCare Held Risk	$3.9M	$3.8M	$1.0M	$125k	$874k	$861k up; $4.4M down
% of Total Risk	*11%*	*9%*	*5%*	*1%*	*2%*	*3.2% up; 12.6% down*
Net Assets/Equity*	$3.9M	$5.6M	$7.0M	$5.7M	$5.7M	$8.0M

SOURCE: OCV FY23 Revised Budget Submission, Appendix 5.1 (FY23 risk amounts); OCV FY23 Budget Submission, Appendix 4.1 (TCOC amounts) and 5.1 (FY23 risk amounts); historical OCV budget submissions for total risk; provider-held risk; OCV-held risk.

*NOTES: Includes $3.9M in reserves (required by GMCB's OCV FY19 Budget Order) plus net assets. OCV also holds a $10M line of credit to support its Medicare risk, as required by Medicare.
SOURCE: Audited financials (through 2021, latest available) and OCV FY23 Budgeted balance sheet (2022-2023).

Condition 11.h

Source of Population Health Funding

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GREEN MOUNTAIN CARE BOARD

- Overall Decrease in Population Health Funding:
  - Initial Budget: $29.9M vs Revised Budget: $26.3M
- Change to DVHA's payment structure for population health
  - PY2022 - $2M from DVHA for VBIF directly to providers
  - PY2023 – All PHM Bonus payments directly to providers
- Mental Health Initiative is fully funded from hospital dues
- DULCE funding shifted from DVHA to hospital dues

Hospital Dues

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- After the withdrawal of BCBSVT, there was approximately $1.8M in budgeted hospital participation fees that remained.
- $1.6M into Mental Health Initiative, $145k to DULCE, remainder to PHM program

Discuss: GMCB's Preferred Approach

VERMONT
GREEN MOUNTAIN CARE BOARD

AMOUNT: $1.8M in budgeted hospital participation fees; could include $98K in operational savings (does not include GMCB ordered 2% admin reduction)

POTENTIAL APPROACHES: Note that all funds must be "reasonably related to ACO Activities" to be compliant with federal law.

1. **Reduce fees based on the loss of attributed lives**
   - Accurately reflects loss of attributed lives but does not provide relief to impacted primary care practices
2. **Reinvest fees into existing OneCare primary care programs.** Some possible examples:
   - Raising Base PMPMs in other payer programs (provides timely relief for impacted primary care providers in 2023 but could lead to reduction in base PMPMs in 2024)
   - Raising Bonus payment amounts in other payer programs (provides relief for impacted primary care practices and avoids reduction to base PMPM in 2024; bonus payments are paid later after quality measures are final)
3. **Reinvest fees into other ACO programs** (e.g., other ACO PHM activity)
   - May not go to primary care providers; increases investment in population health; potential reduction in 2024

Condition 11.j

Commercial FPP Targets

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GREEN MOUNTAIN CARE BOARD

- No change made to the FPP targets, which were set at 0%, since last reported in July 2022; the withdrawal of BCBSVT resulted in the removal of all commercial FPP amounts.

ACO Budget & Financials

Key Takeaways

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GREEN MOUNTAIN CARE BOARD

- New payer program
- Changes in risk corridors and OCV-held risk
- Addition of population health initiative
- Hospital fees spent on population health funding
- Reduction in operating budget

FY23 Budget Order Conditions

VERMONT
GREEN MOUNTAIN CARE BOARD

Condition		Status as of May 3, 2023	Board Action
1	ACO Benchmarking System	Under review	Discuss 5/17
2	Reporting Manual	Reports submitted throughout year	Monitor
3	Data Analytics Transition	Review ongoing	Monitor
4	Scale Target Initiatives and Alignment	Contracts and forms submitted. Note: GMCB APM Scale report (2022 and preliminary 2023 scale results) due June 30, 2023.	Monitor
5	Resubmitted Budget after BCBS Withdrawal	Submitted on January 31, 2023.	Complete
6	Benchmark Trend Rates	Contracts submitted	Monitor

Note: Dates may be subject to change.

FY23 Budget Order Conditions

VERMONT
GREEN MOUNTAIN CARE BOARD

Condition		Status as of May 3, 2023	Board Action
7	FPP for FY24	First of two reports submitted	Monitor
8	Work with MA plans in VT to develop scale qualifying programs	Condition to be edited (technical correction)	Vote on technical correction; discuss 5/17
9	Risk Model, seek approval if changes	Reviewed in Revised Budget	Vote
10	Notify of any material change to budget	Reviewed in Revised Budget; no amendment requested to date	Discuss 5/17
11	Revised Budget documentation	Completed	None
12	Revised Budget presentation	Expected May 5, 2023	Hearing May 5

FY23 Budget Order Conditions

VERMONT
GREEN MOUNTAIN CARE BOARD

Condition		Status as of May 3, 2023	Board Action
13	Operating Expense reduction	Budgeted as ordered	Monitor
14	Notify GMCB within 15 days if OneCare uses reserves, adjusts participation fees, or uses its line of credit	Ad hoc, no update at this time	Monitor
15	Submit revised proposal for PHM programs if not fully funded as detailed in FY23 Budget	Reviewed in Revised Budget; loss of PHM dollars due to loss of payer program/attributed lives	Vote; discuss 5/17

FY23 Budget Order Conditions

VERMONT
GREEN MOUNTAIN CARE BOARD

Condition		Status as of May 3, 2023	Board Action
16	Blueprint and SASH Funding; OCV to hold at least $3.9M in risk	Budgeted as ordered	Monitor
17	OneCare's administrative expenses must be less than health care savings across duration of APM Agreement	Assessment anticipated in June 2023. Staff designing analyses.	Monitor

FY23 OCV Budget Timeline

VERMONT
GREEN MOUNTAIN CARE BOARD

- **5/5** – OneCare Hearing on FY23 Revised Budget
- **5/17** - GMCB Staff Presentation – OneCare FY23 Revised Budget Recommendations
- **5/24 or 5/31** – Potential Vote on OneCare FY23 Revised Budget

Benchmarking Tool

- The goal is to improve performance of the ACO in the areas of Total cost of Care (TCOC), Quality, Utilization, Patient Engagement/Satisfaction, and Clinical Appropriateness utilizing comparative data to measure performance.

Attributes of an Effective ACO Benchmarking Tool

- A robust benchmarking tool is one that is established in the ACO industry with a significant number of ACO users (at least 50 ACOs)
- Measures performance in a timely manner in the key areas of cost, quality, patient engagement/satisfaction, utilization, and clinical appropriateness
- The ACO data is trended and compared to peer performance using standard data measures with peer ACOs by specific area/measures
- Identifies top performing ACO peers by specific area/measure
- ACOs participating in the peer group and measures are transparently identified
- Allows for the identification of the reasons for top performers by specific area/measure
- Provides a mechanism to determine priority opportunities for improvement through the use of an evaluation model such as return on investment (ROI) methodology
- Includes the development and implementation of measurable performance improvement plans
- Priority improvement opportunities are integrated into the ACOs annual quality and performance improvement plan, budget, and compensation plans
- The cost of and results of performance Improvements are measured and tracked to evaluate the ROI of the benchmarking tool

18 V.S.A. § 9382

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GREEN MOUNTAIN CARE BOARD

(b)(1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

(A) information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;

(B) the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

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GREEN MOUNTAIN CARE BOARD

(E) any reports from professional review organizations;

(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;

(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

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GREEN MOUNTAIN CARE BOARD

(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;

(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

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(M) information on the ACO's administrative costs, as defined by the Board;

(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;

(O) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and

(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.

Acronym List

VERMONT
GREEN MOUNTAIN CARE BOARD

- ACO—Accountable Care Organization
- AHS—Vermont Agency of Human Services
- AIPBP—All-Inclusive Population-Based Payment
- AMC—Academic Medical Center
- APM—All-Payer Model
- BCBSVT—Blue Cross Blue Shield of Vermont
- CAH—Critical Access Hospital
- CEO—Chief Executive Officer
- CHT—Community Health Teams
- CMMI—Centers for Medicare & Medicaid Innovation
- CMS—Centers for Medicare & Medicaid Services
- CPR–Comprehensive Payment Reform Program
- DEI—Diversity, Equity, and Inclusion
- ED—Emergency Department
- FFS—Fee-for-Service
- FPP—Fixed Prospective Payment
- FQHC—Federally Qualified Health Center
- FY – Fiscal Year
- GAAP (or US GAAP) – Generally Accepted Accounting Principles in the United States
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HCC—Hierarchical Condition Categories
- HCP-LAN—Health Care Payment Learning and Action Network
- HSA—Hospital Service Area
- IIP—APM Implementation Improvement Plan (AHS)
- I/S—Income Statement
- KPI—Key Performance Indicators
- OCV—OneCare Vermont
- QHP—Qualified Health Plan
- OpEx—Operating Expenses
- PCMH—Patient-Centered Medical Home
- PCP—Primary Care Provider
- PHM—Population Health Management
- PKPY—Per-Thousand Per-Year
- PMPM—Per-Member Per-Month
- PMPY—Per-Member Per-Year
- PY—Performance Year
- ROI—Return on Investment
- UVMHN—University of Vermont Health Network
- SNF—Skilled Nursing Facility
- SS/SL—Shared Savings/Shared Losses
- SASH—Support and Services at Home
- TCOC—Total Cost of Care
- VBIF—Value Based Incentive Fund